Editorials

What About 'Private Practice'?

PRIVATE PRACTICE has long been an article of faith among many physicians. Those who choose to run for political office in organized medicine often use the preservation of private practice as a kind of slogan for their political platform. And there is a segment of the practicing profession that even now is trying to develop a political power base to "save" the private practice of medicine. The term private practice seems to have a high place in the group think of much of the medical profession. But few seem to ask themselves just what does the term mean, what is good or bad about it or what is its relevance to the way much of medicine is practiced and much of health care is delivered today.

For some, private practice equates with fee for service in patient care, and all that is good and bad about this system of payment. Proponents point out that only in this system is the doctor clearly working for the patient, since it is only the patient who pays the fee. They also point out that private practice, as exemplified in the fee for service system, best preserves privacy and confidentiality between doctor and patient, and is the system closest to what medical care is all about—that is, a patient who seeks help and a doctor who is willing and able to give help. And on the philosophical plane, it is held that the private practice of medicine fosters individual responsibility and individual freedom, or "free choice" on the part of patients. This system worked well in simpler times when there was more independence and less interdependence in patient care than exists today, and when physicians carried most of medical technology in their heads or in their black bags, and depended heavily on trust and confidence to bring what solace and comfort they could to their patients.

But the times have changed. There is now much more interdependence among physicians in the way they practice, and much more interdependence among physicians, their patients and the third parties that pay for much or all the care. In this new and much more interdependent world of health care, one may ask just how private can private practice any longer be? The word private can be defined as pertaining to an individual person, private as opposed to public (that is, government), or private, that is, not open to the public, as in private property. Clearly, in these terms there have been serious erosions into the traditional private practice of medicine. There has been an obvious trend toward depersonalization of the doctor-patient relationship, patient care is more open to peer and public scrutiny, and even the courts are publicly examining what happens in the "private" relationships between doctors and their patients. One can only wonder if private practice is becoming an empty slogan, or even an anachronism in this modern day.

In these days of high-tech medicine and of high finance in health care, there is a real and present danger that the personal and therefore private happening that occurs between a doctor and a patient, which is the very essence of medical practice, will be crushed by the massive steamroller of modern medical technology and the ever more bungling efforts in both the public and private sectors to limit the cost of health care. As traditional medical practice (and for many physicians this means private practice) is disassembled by modern technology and present-day economics, we must somehow see to it that physician responsibility to patient, confidentiality in patient care and the element of caring that develops in a personal relationship between doctor and patient are not lost, but rather preserved and strengthened. Patients, and especially sick patients, are in no position to do this. It can only be done by physicians, individually and through their organizations. What is needed is a rededication of the medical profession to the human side, if not the economics, of the private practice of medicine. This is both an individual and a professional responsibility of a high order. And it is still not too late to stem the tide. Or is it? Some affirmative action by physicians and organized medicine may be needed. It might make a significant contribution to the future of patient care.

MSMW

Is There an Exercise RDA for Health?

CURRENT ATTITUDES within the medical profession regarding the role of exercise in clinical practice vary widely. Claims are made by some physicians that exercise improves physical fitness but does nothing for health,[1] while others, having access to the same published information, promote exercise and physical fitness as a major preventive and therapeutic modality for various chronic degenerative diseases and psychological disorders.[2] However, thoughtful analysis of available data appears to have led most health professionals to the general conclusion reached by Phelps elsewhere in this issue: while exercise obviously is not a panacea, there are sufficient data to warrant carefully including it in an overall program of health promotion and to use it as part of a treatment plan for various medical conditions.[3,4] Major unresolved questions include (1) Does exercise cause an improvement in health or is being more active just another attribute of already healthy people? (2) What is the exercise stimulus required to improve clinical status? and (3) If a causal link exists, how much of what type of exercise is required to achieve specific health benefits?

Exercise and Functional Capacity

There should be no doubt that exercise training is the major clinical tool we have to increase functional capacity or physical fitness. Nearly all clinically healthy persons and ambulatory patients can increase their functional capacity by performing appropriately designed exercise programs. Such improvements in patients whose capacity limits their ability for self-care, gainful employment or quality of life should be considered an important aspect of comprehensive therapy whether or not they lead to a decrease in disease progression or mortality. The prescription of exercise for the maintenance or improvement in functional capacity will become even more important in the future as the average age of the patient population continues to increase.

Seeking a Causal Relationship

Due to the lack of adequately designed randomized clinical trials, most data supporting the contention that exercise leads to decreased morbidity and mortality come from prospective observational studies. A legitimate concern regarding these studies is that of selection bias. Did the inactive